INCIDENT REPORT / INITIAL

Name:_____DOB:___/___/_____
Date / Time of incident:_____
Date / Time incident reported:_____
Reported by: (name/title)_____
Did reporter directly observe the incident?_____

Incident Categories (check one):

(1) Unexpected / Suspicious Death
- ☐ Accidental
- ☐ Suicide
- ☐ Unusual circumstances
- ☐ Other unexpected / sudden death

(2) Suicide Attempt
- ☐ First known attempt
- ☐ Repeat attempt

(3) Unexpected Hospital Visit
- ☐ Medical
- ☐ Psychiatric
- ☐ ER

(4) Near Drowning
- ☐ Bathtub
- ☐ Swimming Pool
- ☐ Other body of water

(5) Assault
- ☐ Sexual – Alleged victim
- ☐ Sexual – Alleged perpetrator
- ☐ Physical – Alleged victim
- ☐ Physical – Alleged perpetrator

(6) Missing Person
- ☐ Law enforcement contacted
- ☐ Law enforcement not contacted

(7) Medical Treatment due to Injury:
_____
_____

(8) Fire
- ☐ Intentional – Started by Individual
- ☐ Intentional – Not started by Individual
- ☐ Accidental – Started by Individual
- ☐ Accidental – Not started by Individual

(9) Suspected Mistreatment
- ☐ Alleged Physical Abuse-Victim
- ☐ Alleged Verbal Abuse – Victim
- ☐ Alleged failure to provide needed supports
- ☐ Alleged failure to provide needed supervision

(10) Physical Altercation
- ☐ Person to person – Alleged victim
- ☐ Person to person – Alleged perpetrator
- ☐ Individual to staff

(11) Property Damage
- ☐ Provider property damaged
- ☐ Personal property damaged
- ☐ Public property damaged
- ☐ Another person's property damaged

(12) Theft
- ☐ Alleged victim
- ☐ Alleged perpetrator

(13) Other Criminal Activity
- ☐ Alleged victim
- ☐ Alleged perpetrator

(14) Transportation Accident
- ☐ Provider transportation
- ☐ Public transportation
- ☐ Private vehicle
- ☐ Pedestrian
- ☐ Recreation vehicle
- ☐ Bicycle
- ☐ Other:_____

(15) Emergency Relocation

(16) Unplanned Transportation Restraint

(17) Other:
- ☐ Misuse of funds / Fraud
- ☐ Staff involvement with Law Enforcement
- ☐ Behavioral incident in the Community
- ☐ Behavioral incident involving Law Enforcement
- ☐ Ongoing or escalating series of minor events
- ☐ Community Complaint
- ☐ Other:_____

INCIDENT REPORT / Continued

Member Name:_____

1. Did injury result from incident? _____

_____

2. Cause of injury; check all that apply:

☐ Self-Inflicted	☐ Fall	☐ Motor Vehicle
☐ Staff Inflicted	☐ Equipment	☐ Seizure
☐ Peer Inflicted	☐ Transfer / Handling	☐ Other
☐ Inflicted by Other	☐ PICA / Eating non-food items	☐ Unknown
☐ Environmental	☐ Insect / Animal Bite	☐ N/A

3. Family / Guardian notified: Date:_____ Time_____

Name of person making contact: (name, title, agency):_____

_____

4. Name of Family member / Guardian receiving notification: (name, relationship, any follow-up indicated):_____

_____

_____

5. Adult / Child Protective Services notified: Date_____Time_____

Name of person notified:_____

6. Law Enforcement notified: Date_____Time_____

Person notified:_____

7. List actions taken to protect health/safety/rights of the individual:_____

_____

_____

_____

8. Please describe any counseling provided to the individual about interventions, including budget, to prevent a similar incident from occurring in the future:_____

_____

_____

9. Location of incident, (check one):

☐ Individual's Home	☐ Family Residence	☐ Work Site
☐ School	☐ Day Service	☐ Vehicle
☐ Hospital	☐ Community	☐ Respite
☐ Unknown	☐ Residential Setting	☐ Other:_____
		_____

INCIDENT REPORT / Continued

Member Name:_____

10. Location name and address, if any:_____
_____
_____

11. People involved with incident (add additional sheets as needed)

Name	Relationship	Telephone	Involvement

12. Reporter Name:_____Title_____

13. Signature of Reporter:_____Phone_____

14. Date/Time of Report:____/____/____ _____
Date Time

Comments:_____
_____
_____
_____
_____
_____
_____
_____
_____

INCIDENT REPORT ADDENDUM

HOSPITAL VISIT / CARE FACILITY VISIT

Member Name:_____ Date_____

1. Hospital/Facility:_____
2. Date of Visit:____/____/____
3. Time in ER / Urgent Care / Crisis Unit:
- ☐ <6 Hours
- ☐ 6-12 Hours
- ☐ 12-24 Hours
- ☐ >24 hours Unknown

4. If admitted to an Acute Care Facility:
Admitting diagnosis:_____
Date of Admission:_____Date of Discharge:_____

5. Instructions upon Discharge:

_____
_____
_____
_____
_____

6. Current Status – Changes occurring with facility visit: (check all that apply)
- ☐ Decrease in daily living capabilities
- ☐ Increase in daily living capabilities
- ☐ No Change Noted
- ☐ New health status:
  - _____ temporary condition, expected to improve
  - _____ progressively deteriorating condition
  - _____ permanent condition, not changing
  - _____ terminal condition
  - _____ unclear at this time

Comments:_____
_____
_____
_____
_____
_____
_____

INCIDENT REPORT ADDENDUM

HOSPITAL VISIT / CARE FACILITY VISIT (Continued)

Member Name:_____

7. Primary Care Physician:
Name:_____
Address/Phone:_____

8. Any follow-up appointments: Specify Provider name, date/time of appointment.

Provider	Name	Date/Time	Comments
PCP: Primary Care Physician			
Admitting Physician			
Surgeon			
Specialist			
Outpatient Psychiatrist			
Admitting Psychiatrist			
Other:			
Other:			
Other:			

9. Additional / Clarifying Information:_____
_____
_____
_____
_____
_____
_____
_____

INCIDENT REPORT

FINAL REPORT

Member Name:_____

ACTION STEP	TARGET COMPLETION DATE	RESPONSIBLE PARTY

1. Name/title of person finalizing report:_____
2. Agency:_____
3. Address / Phone:_____
4. Signature:_____
5. Date / Time of review_____/____/____ _____am/pm
   Date Time

Comments:_____
_____
_____
_____
_____
_____
_____
_____

DRAFT 4.28.08